Business Acumen Learning Collaborative Subcommittee

Utilization Review

1/19/18

Meeting Minutes

Participants- Cindy Robertson (DRC – cindyr@drcnh.org), Sofia Hyatt (Region 9 – Shyatt@communitypartnersnh.org), Debbie Gaudreault-Larochelle (ISN – gaudreault@isnnh.com), Le'Ann Milinder (IPPI – lmilinder@ippi.org), Julia Haas (Region 4 – jhaas@communitybridgesnh.org), Lorrie Winslow (NeuroRestorative – lorrie.winslow@neurorestorative.com), Frank Truman (Region 7 – frank.truman@moorecenter.org), Maureen Rose Julian (Region 7 – maureen.rose-julian@moorecenter.org), Jonathan Routhier (CSNI – jrouthier@csni.org), Erin Hall (BIANH – erin@bianh.org), Kristina Ickes (DHHS – Kristina.Ickes@dhhs.nh.gov), Sandy Hunt (BDS – sandy.hunt@dhhs.nh.gov)

- Restructuring occurred at DHHS that created the division of Long Term Supports and Services (LTSS) which includes BEAS and BDS. Chris Santaniello is the Director of LTSS. The hope is to include both BEAS & BDS in this Utilization Review process to try to streamline the activities of both departments. The goal of the subcommittees within the Business Acumen Training is to identify paths to get to a more streamlined approach across the board.

- Sandy provided a refresher review of NASUAD and Business Acumen (see attached PowerPoint).
    - Want to ensure that CBOs all have strong business acumen to be able to easily adapt to change sin the business environment
    - What happens to us as a system – and how are we able to respond?

- Sandy provided a copy of a self-assessment for agencies to use to conduct a self-review of their current business acumen. These assessments are related to managed care so they may not fit perfectly but can be useful tools. See slide deck for the link to this toolbox.
    - A suggestion was made that BDS & BEAS also conduct a self-assessment to review their own business acumen.

- Review of NASUAD's overall goal – to build capacity of disability community organizations to contract with integrated care and other health sectors (see PowerPoint).
    - Integrated Delivery Networks (IDNs): collaboration of partnerships across regions to deliver on outcomes to get value based payment– sharing health care info readily.
    - Goal is to break down the existing silos.

- Review of Key Activities (see PowerPoint):

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- What does Utilization Review look like?
- NASUAD encourages additional contracts to outsource work or provide resources to outside agencies (e.g. an area agency with strong clinical services, like the Moore Center, contracting out their clinical resources to outside CBOs to increase revenue).

- **Utilization Review**:
  - One of the focus areas identified in NH's proposal to NASUAD.
  - Target dates listed in PowerPoint were dates that were listed in the original proposal to NASUAD and are subject to change.
  - Priority is to make the most of the resources we already have available to us.
  - **Goal**: ensure that care needed is being received, administered by proven methods, by appropriate providers and delivered in appropriate settings.
    - Insurance companies have Utilization Management (UM) departments that monitor utilization patterns.
    - **Four areas to look at:** population, needs, methods and settings
  - Fitting services to the individual – needs change and are fluid so the goal of this group is to come up with ideas to help us be more fluid with how we respond across systems to people's changing needs.

- **CFI**: does have the ability to adjust budgets on a daily basis as needs change. DD/ABD/IHS does not have this flexibility.
  - Systems are very different and have very different operations across systems.
  - The hope is to identify processes that apply to CFI and then to identify processes that apply to the other 3 waivers.

- **High Cost Budget Review**: calls occur for any budget that is over a certain cost threshold. One mechanism for working to be leaner with resources.

- **Post Payment Review Process:** occurs with the IHS waiver – will start applying to DD & ABD waivers. Were services that were promised delivered? If not, why?

- **Waitlist Registry Tracker**: currently just being used for DD but BDS has requested that ABD and IHS be put into the Waitlist Registry Tracking as well.
  - Helps to identify when delays occur, why they occurred and when the programs actually start. Used to isolate unused funds that can be reallocated.

  - **Proposed Outcomes**: goal is that by 6/30/18, at least 5% of statewide DD, ABD, IHS wait list needs will be managed with existing funds from within the system.

- Question: 5% of what?
- Waitlist needs is considered to include As, Bs and Cs

- **Vacancy Funds**: average $5-7 million per year. These funds are counted on each year and are used to address urgent funding needs that arise**.**

- **ABD Wait Times**: because brain injuries are less predictable, people end up waiting in hospitals and nursing homes for extended periods of time.
  - Lorrie reported that NeuroRestorative's NH admissions from hospitals are less than 4% and that in other states, their admissions from hospitals are about 50%.
  - ABD waiver in NH is very different – many other states have their ABD waivers set up as rehab waivers which helps to decrease wait time in hospitals post injury because people can be served by rehab providers using the ABD waiver to help obtain better outcomes post injury.
  - ABD waiver in some states is set up for services and then people pay for their own housing.
  - Unlike other states, NH's ABD Waiver is at a skilled nursing level.
  - Many new ABD clients have substance abuse issues.
  - Concern was expressed from the area agencies at the table upon hearing that people with brain injuries are waiting in hospitals because we get people onto the ABD waiver and into services pretty quickly upon learning about their cases.
  - It was reported that 3-6 months post injury, individuals haven't been made known to AAs yet but BIANH does work to identify people at this point.
  - BIANH tries to provide information to AAs when they hear about people who've experience brain injuries or they look to the CFI waiver to see if it may be a better fit.
  - BIANH reaches out to lots of hospitals to try to get them to share information when people come in with brain injuries; however, the communication does not always occur.
  - Need to get acute care hospitals on board with working together as well – this "transition period" is essential for people post brain injury just as much as it is essential for people who are going to be turning 21.
    - Theme: transition periods are key points!

- **Critical Time Intervention Training**: was suggested as a resource since it's a methodology that pulls all necessary resources together to prevent people from falling through the cracks.
  - The training is mostly around mental health issues, homelessness and substance abuse so it needs to be adapted for the DD/ABD population.
  - Has been utilized for the IDN work that is being done

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- **APS**: closing cases within 24-48 hours when people are waiting for CFI services (in transition). Key for them to be involved. Also key for BH services to be involved.

- **Emergency Department Protocol:** was adopted recently for DD/ABD clients.
  - Would be helpful on the CFI side as well.
  - BIANH notified when people press their emergency response buttons but the MCOs are not always notified when a client on the CFI waiver is in the ED.
  - Sandy will share the ED Protocol with the CFI agencies

- **CFI Waiting List**: is not formally tracked like the DD, ABD & IHS waitlists.
  - **MEA**: an assessment needed for CFI clients before they start. Wait times have begun improving but are still a huge issue. After the MEAs there is a lag with the eligibility determination, approvals and then after all that services can finally begin. Similar to wait times with PAs in DD/ABD process.
  - **Staffing Crisis**: this impacts how long it takes for services to get up and running.
  - CFI lacks the organizational structures of the AAs (no middle man between the department and the service providers)

- **Big Picture Issues**:
  - Historical budgets are a huge issue across the board. They don't provide any room for flexibility
  - Would be a huge value to allow agencies to use they money they have as they need – increasing flexibility (aka business acumen)
  - Current system creates an imbalance where there are "donor regions" and "recipient regions" and we need to try to find a way to move away from this practice
  - Need to get to a place where we are determining levels/rates based on individualized needs
  - CPS billing used to be monthly and is now by the quarter hour which is far less person-centered.
  - Residential payments decreasing when someone's needs "become less complex" – ultimately leads to destabilization down the road and providerships coming to an end (which is in turn more expensive).
  - Value Based Payment Subcommittee is going to work to hopefully incentivize person centered value based reimbursement.
  - Continuum of care is an issue – lack of step down options. Clogs up the system and makes it hard for people to move to less restrictive options as their needs decrease.
  - Aging population – has very different needs than those people coming into services.

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- **Utilization Review**:
    - Region 9 has daily utilization meetings for different departments within the agency. There are regular meetings to review utilization of residential, day/CSS, SEP, case management, waitlist and other services. Regular tracker meetings each week to check on outstanding PAs and other items that require follow up.
    - Helps to identify issues with utilization patterns; provides an opportunity for staff to follow up to find out why utilization is low and triage that issue when it occurs (e.g., staffing issues).
    - Identifies underutilized funds and helps with quickness of using funds for other items, putting them in the zunk, etc.
        - Sofia will follow up with staff at Region 9 to have Sandy and Jonathan sit in on a utilization meeting to see how it runs and how it works to make the agency more efficient

- **ITS Metrics**: could be a possible way to look at utilization review – reviewing performance outcomes. Currently only 12 clients whose metrics are being reviewed.
    - Increased metrics mean increased administrative burdens because it pulls resources from service delivery to administrative work unless there is technical assistance provided that is integrative and easily accessible.
        - IT Subcommittee: we need to be sure these ideas are brought to this committee and that any ideas for IT related items are realistic from an IT perspective.
        - Sandy shared that BDS is looking at doing a dashboard to review the actual cost of providing services to compare what people are actually being paid
            - CFI contains many "mom & pop" providers – we need to be sure that these steps are practical across all systems and waivers so that valuable providers don't leave the table.

- **How does Conflict Free Case Management impact the work we are looking to do?**
    - Situation will change dramatically as agencies make changes – but we need to move forward anyway – can't stay stagnant just because other changes are occurring.
    - Key is to be at the table (not on the menu)!

- It was discussed that as we look to create new processes, we need to identify ones that are being replaced versus just adding to an already astronomical workload.
- How can we assess the actual time providers spend on client facing activities versus administrative tasks. This impacts costs to the system long term by increasing turnover.

- Lorrie from Neuro reported that their NH administrative costs are covered by their work in the state of Maine
- The more administrative tasks that are added, the less time there is to actually support the people that we are here to serve.
  - Sandy's response was that this will be up to the AAs to manage; Sandy will ask the other 5 states for any ideas based on our conversations/ideas today.
- We discussed the possibility of HRSTs being completed by providers instead of CMs to free up time for utilization review. However, this adds to the administrative burden of providers.
  - How would CMs doing this review help? Any changes to practices with CMs (e.g., who rates HRSTs) should not be decided at this meeting and need to be presented as suggestions to the CM Supervisors Group.

- **Budget Realignment**: we need to look at existing budgets (not just waitlist savings). There are some budgets that are ready to decrease and some that need enhancements because they are so outdated.
  - Realignment – using decreases in high budgets to bump up the lower budgets
  - CFI is able to bump their budgets up/down without state approval. This is much more fluid than the DD/ABD/IHS processes. CFI has "soft budgets."
    - Anything up to 50% of nursing home level of care increases are able to be done without need for outside approval. Done with CMs, driven by need. CM systems typically different than ours with DD/ABD.

- Sandy completed a responsibility chart for follow up tasks to be worked on before our next meeting. Areas are outlined below and Sandy will send out the chart to the group.
  - **Transition**: population, needs, services & setting all need to be reviewed. Identifying networks to engage with to provide increased training and education so we become aware of people with brain injuries as soon as possible. Need to tap into community organizations such as schools, hospitals, churches, etc. so we can help people as quickly as possible when they're in a vulnerable state post injury.
    - **ED Protocol**: review for possible use with CFI waiver clients
    - **Critical Points for Delays in Services**: should be assessed across all waivers
  - **Historical Budgets**: we need to determine the actual level of costs of providing services and compare to what is being paid out now.
  - **Level of Care**: Review of Community Partners' utilization review process (Sandy and Jonathan will attend a meeting).

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Next Meeting- 2/22 from 12-2pm at BDS

Minutes recorded by Sofia A. Hyatt